Consulting as a Strategy for Knowledge Transfer

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Academic researchers who work on health policy and health services are expected to transfer knowledge to decision makers. Decision makers often do not, however, regard academics' traditional ways of doing research and disseminating their findings as relevant or useful. This article argues that consulting can be a strategy for transferring knowledge between researchers and decision makers and is effective at promoting the "enlightenment" and "interactive" models of knowledge use. Based on three case studies, it develops a model of knowledge transfer–focused consulting that consists of six stages and four types of work. Finally, the article explores how knowledge is generated in consulting and identifies several classes of factors facilitating its use by decision makers.

Key Words: Knowledge transfer, consulting.

IN MANY INDUSTRIALIZED NATIONS, HEALTH policymakers and health services administrators are striving to develop "evidence-based" modes of decision making (Moynihan 2004). They are increasingly being encouraged to turn to health services researchers and other academics as sources of knowledge that can be applied to policy and service delivery decisions (Black 2001; Kindig, Dunham, and Eisenberg 1999; Lavis et al. 2002; Whiteford 2001). Knowledge transfer, defined by the Canadian Institutes of Health Research (2004, 4) as "the exchange, synthesis and ethically sound application of knowledge within a complex system of relationships among

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researchers and users," has thus become an expectation for academic researchers whose work is relevant to health policy and health service delivery.

Decision makers often do not, however, regard academics' traditional ways of doing research and disseminating their findings as useful. The problem of utility may be partly explained by the frequently cited "two communities" theory (Caplan 1979), which points to cultural differences like time frames and language as barriers to knowledge exchange between researchers and decision makers (Crosswaite and Curtice 1994). Perceptions of whether decision makers actually use research knowledge also may reflect differing cultural expectations. Academics often imagine that research-based knowledge will play a central and determinative role in the decision-making process and thus expect to see a direct correspondence between their findings and policy or practice decisions (Black 2001).

The role of research in decision-making environments is infinitely more complex than in this imagined scenario of instrumental use. Carol Weiss's (1979, 430) explication of the seven "meanings of research utilization" in public policy stands as the paradigmatic account of the many different types of use. In the *intellectual enterprise model*, both research and policy are seen as social products that "respond to the currents of thought, the fads and fancies, of the period." In the *knowledge-driven model*, the research process itself drives the discovery, development, application, and use of knowledge in policy development. Weiss describes the *problem-solving model* as "the direct application of the results of a specific . . . study to a pending decision" (1979, 427). In the *political model* of research use, research evidence is used as "ammunition" to support predetermined conclusions. Similarly, in the *tactical model*, research becomes an excuse for delaying a decision or a means of deflecting criticism. In the *enlightenment model* of use, "concepts and theoretical perspectives that . . . research has engendered . . . permeate the policy-making process" (Weiss 1979, 429). Finally, Weiss defines (1979, 428) the *interactive model* as a "disorderly set of interconnections and back-and-forthness" in which knowledge is produced and used in iterative collaboration.

Over the last 20 years, the consensus that effective knowledge transfer is necessarily an interactive process has grown (Huberman 1990, 1994; Innvaer et al. 2002; Lavis et al. 2002). Unlike earlier understandings of transfer as a unidirectional activity—understandings that had knowledge either flowing from researchers to users or being extracted from

researchers by users (Landry, Amara, and Lamari 2001)—the interactive model (which Jonathan Lomas [2000] calls "linkage and exchange") conceives of knowledge transfer as a collaboration in which researchers and users together develop knowledge in order to identify, understand, and solve real-world problems (Anderson et al. 1999; Davis and Howden-Chapman 1996; Denis and Lomas 2003; Lomas 2000).

Recent literature has delineated several specific ways in which academic researchers and decision makers can use the interactive model of knowledge transfer in the health sector. Goering and her colleagues (2003) and Coburn (1998) described examples of formal and informal partnerships used to structure knowledge transfer relationships between academic research units and government agencies charged with making and promulgating policy decisions. Two studies of knowledge transfer efforts by Canadian health research organizations (Canadian Population Health Initiative 2001; Lavis et al. 2003) reported on the use of strategies like outreach, researcher and user capacity-building activities, tailored products and messages, and the engagement of users in the research process. In addition, some research organizations are developing the role of knowledge broker, vesting many of the interactive functions of communication and collaboration in a defined position (Canadian Health Services Research Foundation 2003).

In this article we argue that the practice of consulting may be another tool for interactive knowledge transfer between academics and decision makers, one that is particularly effective at promoting the enlightenment and interactive models of knowledge use, which to most academic researchers may be less familiar than instrumental models. We analyze several case studies of consulting projects in order to create a model of knowledge transfer–focused consulting and to identify some of the factors that appear to promote the effective transfer and use of knowledge in consulting projects. Our intention in this presentation is twofold: first, we hope to contribute to the literature more generalizable information about the conditions that facilitate interactive knowledge transfer, and second, we wish to advocate for the wider application among academics of consulting as a knowledge transfer strategy.

Literature Review

The bulk of the literature on consulting focuses on two kinds of consulting practice: consulting to businesses (e.g., various forms of management

or information technology consulting) and consulting to human services organizations (e.g., mental health or program consulting). Much of this published work has taken the form of "how-to" guides. With a few notable exceptions (Gallessich 1985; Van Houten and Goldman 1981), consulting did not attract scholarly or critical attention until the 1990s (Fincham 1999; Hislop 2002).

Consulting is broadly defined as a process of transferring expertise, knowledge, and/or skills from one party (the consultant) to another (the client) with the aim of providing help or solving problems (Block 2000; Druckman 2000a; Gallessich 1985; March 1991). The parameters of the process are described in a contract, and the client pays the consultant (Holtz 1985). In some types of consulting, this dyadic definition is expanded to a triadic one, with the third spot occupied by the individual(s) who constitute the "problem" to be solved (Dougherty 1990; Gallessich 1985). The literature portrays consulting as a staged process, with specific tasks and functions taking place at different times. The number of stages reported ranges from four (e.g., Dougherty 1990) to seven or more (e.g., Lippit and Lippit 1978).

Clients may be situated in the public, private, or "third" (nongovernmental organization) sectors (Goodstein 1978; Kubr 1996). Their need for consulting is linked to three types of factors: sectoral changes that cause them to look for very specialized forms of expertise, budgetary limitations that make contracting the most cost-effective means of obtaining this expertise, and political environments in which using consultants becomes a way of increasing legitimacy (Gallessich 1982; Sturdy 1997; Van Houten and Goldman 1981).

Each sector has different characteristics, as do the organizations within those sectors. The literature points to several domains of sectoral/organizational characteristics as being important to the consulting process: the culture (including values, hierarchy of power/authority, demographics) of the sector or organization, the functions or goals of the sector or organization, the nature of the presenting problem, and the accountability structures in which the sector or organization is situated (Fincham 1999; Golembiewski 1987; Goodstein 1978; Kubr 1996; Van Houten and Goldman 1981).

Specific consulting approaches and practices vary in their ideologies, values, goals, methods, interventions, outcomes, and ethics (Dougherty 1990; Druckman 2000a; Gallessich 1982, 1985; Kratochwill and Bergan 1990). Consulting may emphasize either process or product (Kubr 1996;

Ulvila 2000). Gallessich noted that different approaches to consulting are based on different "bodies of knowledge consisting of varied concepts, principles, and techniques" and thus employ different "processes through which consultants work with [clients] to achieve goals" (1985, 345, 346). She argued that these variations are manifested in different rules for the roles and relationships of consultants and clients. Indeed, consultants (and, by extension, clients) are described as playing various roles—as the expert, the advocate, the teacher, the fact finder, the technician, the adviser, the bridge builder, the storyteller, the applied theoretician, and even "the witch doctor" (Block 2000; Czarniawska and Mazza 2003; Dougherty 1990; Druckman 2000a)—and their approaches have been described as falling along a continuum of directiveness ranging from advisory to prescriptive (Lippit and Lippit 1978). Scholars have recently noted a decline in prescriptiveness, with a distinct trend toward consultants and their clients working in more mutual and collaborative ways (Czarniawska and Mazza 2003). Hislop (2002) and Sturdy (1997) termed this an *interactive model* of consulting.

Methods

Research Setting

The Health Systems Research and Consulting Unit is a health services and policy research unit housed in the Centre for Addiction and Mental Health, a teaching hospital affiliated with the University of Toronto. In addition to its grant-funded academic work, the unit also has more than 20 years of consulting experience in mental health system planning and policy development and in conducting operational reviews of individual mental health programs, organizations, and systems. The consulting practice was conceived and continues as a corollary to the clinical practice of those units doing medical or clinical research. The consulting practice provides experience with service delivery and policy development to academic researchers who might otherwise not be familiar with the daily realities of mental health practice and policy. Consultants are either scientists or research associates employed by the unit or independent consultants contracted by the unit to work on specific projects. All three authors of this article are employed by the Health Systems Research and Consulting Unit. Although Butterill and Goering are often on the unit's interdisciplinary consulting teams, Jacobson—who collected and

analyzed all the case study data for this article—has not been involved in the unit's consulting practice.

Data Collection and Analysis

We used two techniques to develop a model of consulting and to explore the use of consulting as a strategy for knowledge transfer. First, we reviewed and analyzed the literature pertaining to consulting theory and practice. (The previous section summarizes that review.) Second, in order to understand the processes in using consulting as a strategy for transferring research-based knowledge, we made detailed case studies of three consulting projects completed by the Health Systems Research and Consulting Unit. Throughout our work, we derived our methodological approach from symbolic interactionism (Blumer 1969), grounded theory (Glaser and Strauss 1967; Strauss 1987), and dimensional analysis (Caron and Bowers 2000; Schatzman 1991).

Our review of the literature suggested several important dimensions of variation in consulting that might be expected to affect the outcome of a consulting project. The main ones were the nature of the issue at the center of the consultation, the characteristics of the relationship between the consultant and the client, and the context of the project. In selecting three projects for our study, we tried to maximize the variation among them along these dimensions. In the first project, a solo consultant conducted a study of psychiatric bed use at a rural inpatient facility. In the second, a team of consultants reviewed the organization of court-based mental health services in a large urban area. The third case study looked at a provincewide series of regional assessment projects designed to ascertain the fit between clients' needs and the type and level of services available. Owing to the nature of the unit's work and the need to select recent projects, all were on topics in mental health services and all took place in Ontario in 2001 and 2002, when the province was implementing a program of reform in its mental health system.

Once we had selected the three consulting projects, we collected documents relevant to the projects (e.g., the final reports produced by consultants) and used selective and snowball sampling to identify the people to interview about each project. Almost all the consultants for the three projects participated in the interviews, as did some of the projects' clients. The interviews, which we conducted either in person or over the telephone, lasted between 30 and 90 minutes. All were tape-recorded and

transcribed verbatim. As is typical of this type of interpretive research methodology, the focus of the interviews shifted over time to reflect the developing analysis. While earlier interviews might have been more general in scope, directed at developing an overall understanding of the consulting project, later interviews tended to focus on more specific issues raised in the analysis. The interview portion of the study was reviewed and approved by the research ethics board at the Centre for Addiction and Mental Health.

Our initial analysis of the interview data was guided by concepts that emerged in the literature review. For example, given the emphasis in the literature on consulting as a staged or phased process, we considered the number of stages in the selected projects and what took place during each stage. Later, we concentrated our data collection and analysis on exploring the meaning of knowledge transfer in consulting work. In our interviews with clients, for example, we began to examine the characteristics of projects deemed "successful" and to probe for examples of how the findings and research-based recommendations of consulting projects were or were not being used.

The products of our analysis, and the building blocks of the model presented in this article, were short narrative descriptions of each project, a matrix showing the stages or phases of each project and the work processes that took place in each stage, and an overall list of factors that seemed to facilitate the projects' knowledge transfer objectives.

A Model of Knowledge Transfer–Focused Consulting

The projects we studied can be described as consulting work in which clients contracted for consultants' knowledge, expertise, and skills in order to help develop policy or practice recommendations that were grounded in both context-specific applied research and a broader theoretical and empirical evidence base. These projects proceeded through a series of stages. In each stage, the consultants and the clients engaged in tasks, or work processes, that resulted in specific products. The work processes and products were directed at promoting the consulting work's knowledge transfer goals, which themselves encompassed both product (grounded recommendations) and process (use of the recommendations).

Consulting Stages and Types of Work

Our model of consulting has six stages: preentry, entry, diagnosis, intervention, exit, and postexit. Entry, diagnosis, intervention, and exit are similar to the stages of consulting often described in the literature. In the *entry* stage, consultants and clients define the central issues to be addressed and determine the scope of the consulting project. Consultants devise a research plan and work to develop or adapt an appropriate methodology for completing the investigation. During the *diagnosis*, consultants, usually assisted by their clients, gather and analyze data relevant to the central issue. In the *intervention* stage, consultants and clients work together to interpret the results of these analyses and link them to the broader evidence base, using these activities to develop recommendations. At the *exit* stage, consultants write and present their clients with a final report, a signal that the project has concluded. Although every consulting project goes through these four stages, there often are not bright lines between them. In particular, the entry/diagnosis and intervention/exit stages may overlap.

Although the existing models of consulting usually ignore the preentry and postexit stages, we found them to be crucial to understanding the knowledge transfer outcomes of the three consulting projects. In the *preentry* stage, the context for the consulting project is set: a problem or issue emerges; the clients determine that they cannot address the problem, and they then decide to seek consultants and agree on which consultants to hire. In the *postexit* stage, based on factors related to their own interests or the larger political environments in which they are embedded, the clients either do or do not implement the consultants' recommendations.

Each consulting project requires four types of work: business work, project management work, substantive work, and political work. *Business work* is composed of the work processes that deal with the commerce issues of consulting—for example, budgeting and hiring. *Project management work* encompasses the work processes that move projects from initiation to completion in a timely manner. *Substantive work* is made up of work processes directed at generating, synthesizing, and applying knowledge about the topic that is the focus of the consulting project. For example, in the consulting projects we studied, substantive work included research tasks like conducting literature reviews and syntheses of best practices, collecting qualitative and quantitative data, analyzing

data, and developing recommendations that reflect both the specific project findings and the broader evidence base. Finally, *political work* includes managing both the interpersonal concerns and the political context in which a consulting project is unfolding.

Both clients and consultants conduct all four types of work. Each type of work has its own goals, which may be understood as subgoals of the broader goals of recommendation development and use. The four types of work are not necessarily mutually exclusive. The substantive side of a project may influence the business side (such as when consultants must hire individuals with a certain expertise), or projects may be managed in certain ways in order to navigate particular political issues (as when bureaucratic needs determine the consultants' time line). All four types of work occur at each stage of the consulting process, but the particular focus of the work, and thus the specific work processes, shifts as the project proceeds.

Consulting in Action

The notions of stages and types of work are best illustrated by showing them in action. In this section, we animate the process of consulting to show how it can work to promote knowledge transfer. Although business work and project management work are important parts of the infrastructure of consulting, they appear to be less important to achieving the goal of knowledge transfer. Our focus in these descriptions, therefore, is on the substantive and political work in the six stages of a consulting project.

Consulting Project 1. This project, conducted by a consultant affiliated with the Health Systems Research and Consulting Unit, looked at the utilization of psychiatric beds in an inpatient facility serving two counties in rural Ontario. The impetus for this consultation was a report by the provincial hospital restructuring commission, which had recommended to the Ontario Ministry of Health and Long-Term Care that a number of the facility's beds be closed and reallocated to a tertiary care hospital some distance away. Facility administrators believed that implementing this recommendation would hurt the delivery of services.

The substantive work of the preentry stage consisted of an attempt by the facility administrators and allies at the district health council to gather data supporting their objection to losing beds to the regional tertiary facility. But when they realized that they lacked the skills and

resources for this task, they decided to bring in a consultant. They then had to work on "selling" the idea of hiring a consultant to the broader facility administration and to the bureaucrats who held the purse strings. The decision of which consultant to hire was based on both the reputation of the consultant's affiliation and the previous experience that the consultant was known to have.

During the entry stage, the consultant and the clients negotiated the scope of the project. This negotiation encompassed decisions about the questions to be answered and the data to be collected. The political subtext, however, revolved around the consultant's figuring out what the clients really expected from the project and her making clear to them that her recommendations would be based on the data—that is, that she was not there just to endorse the outcomes they were seeking. The product of these negotiations was the consulting contract.

In the diagnosis stage, the consultant worked with facility personnel assigned to the project to gather and analyze both the qualitative and quantitative data. For example, she conducted informant interviews with administrators and clinical managers, took "snapshots" of inpatient characteristics over a defined period of time, and compared the facility's utilization patterns with those of similar institutions. The data were gathered in a way that would "recognize local expertise" and feel "inclusive," strategies for promoting buy-in as well as for improving the quality of the data.

In the intervention stage, the consultant took her preliminary interpretations of the data back to her informants and the facility administrators, in order to enrich her own understanding of their significance and meaning. Here, too, the feedback process served both substantive—improving the quality of the recommendations—and political—improving the chance for acceptance—aims. As the consultant and her clients reached a consensus on the substantive content of the recommendations, they also negotiated the ways in which the recommendations should be framed and the language in which they should be expressed. (As one client explained, the wrong language could scuttle the recommendations, whereas the right language would promote their implementation.)

At the conclusion of this process, in the exit stage, the consultant wrote a final report that recommended several organizational and programmatic changes to improve the effectiveness and efficiency of bed use and contextualized these changes in the broader best practices literature. Because of the ongoing problems the facility was having with accessing beds at the tertiary hospital, she also recommended that beds

not be reallocated until better linkages could be forged. The consultant presented these findings and recommendations to a broader group of stakeholders. At this presentation the political task was, as the consultant described it, to enhance the audience's "comfort" and "confidence" with the recommendations. To do so, she used a presentation style that mixed compliments about what the facility was doing well with constructive suggestions about how problems might be remedied (a "good news/bad news" format). When some suggestions were met with skepticism, the consultant drew on her experience and the data themselves to reinforce the correctness of her recommendations.

In the postexit stage, after the consultant's contract had been fulfilled, the clients had the task of implementing the recommendations. They needed to develop an implementation plan based on the recommendations, one that would schedule the timing of the changes to be made. The implementation also was a political negotiation, with the clients compromising on the specifics of some recommendations in order to get the broader plans accepted. The consultant's report became a source of authority, a way to "hold people's feet to the fire" in order to get things done. The report was used to argue against the bed closures, an argument that the ministry ultimately rejected. It also was used to promote internal changes, some of which—for example, the designation of several existing facility beds as holding/crisis beds—were adopted.

Consulting Project 2. In this project, a team of seven consultants reviewed the court-based mental health services in a large urban area of Ontario. At the time, the services were being provided by a number of organizations at five courts serving different areas of the city. A judge with administrative authority over the courts wanted to consolidate all mental health services in one city court.

An existing steering committee of service providers and other stakeholders, which had been largely dormant and had some history of conflict within its membership, was remobilized by this plan. The group determined that its best strategy for resisting consolidation would be to develop authoritative evidence through a program review by consultants. After convincing the Ministry of Health to fund such a review, the steering committee solicited proposals from several consulting firms and held a bidders' conference to talk with potential consultants about their needs. The steering committee's political emphasis in this preentry period was on conducting a "transparent" selection process so that the results of the consulting project would not be attacked as biased. In making their selection, steering committee members used criteria like

credibility, expertise, trust, and rapport. The eventual decision to award the contract to the Health Systems Research and Consulting Unit team was unanimous.

Also in this preentry stage, the winning team worked to develop the background needed to write a proposal. This political and substantive preparation included discussions with stakeholders about the "real" issues that were likely to be at stake in the project, as well as the tasks related to writing a proposal.

During the entry period, the team and the steering committee worked together to determine the terms of reference—scope and focus—of the project and to develop a research plan. They decided to add more consulting team members in order to improve the stakeholders' representation and available expertise. In addition, the consulting team and the steering committee agreed on how to handle the possibility of bias in one team member (who had previously been employed by one of the court services organizations).

In the diagnosis stage, the consulting team gathered and analyzed data and continued to work with the steering committee to focus the aims of the review. The team conducted a literature review of the research on court-based mental health services, analyzed information from a systemwide database of client characteristics, held informant and focus group interviews with a number of stakeholder groups, and also reviewed administrative documents. The data were collected, one consultant said, in as "neutral and objective" a manner as possible, in order to forestall any complaints of predetermined findings. As the consulting team better understood the issues at stake in the review, the lead consultant increasingly saw the main task of the consulting project as conflict resolution. Her realization influenced the intervention stage of the project.

In this stage, the consultants continued to work closely with the steering committee, presenting them with the results of their analyses and their preliminary interpretations of these results. As well, the consultants held a daylong workshop on the preliminary findings for all stakeholders. At this workshop, the consultants strove to promote agreement on the interpretations and recommendations and to ensure a "no surprises" final report. They presented their preliminary findings in as "nonprovocative" a fashion as possible and tried to make all stakeholders feel that they had "had a voice."

In the exit phase, the consulting team worked with the steering committee to draw up a set of recommendations and a final report. They

focused on those recommendations for which there had been some agreement at the stakeholders' workshop: not to consolidate services into a single court and to bring more coordination and accountability to the court-based services system. The report drew on the current literature to describe several organizational options for promoting such coordination and accountability; the consultants' own stated preference was for an integrated "lead agency" model. As in project 1, a great deal of effort went into crafting the language of these recommendations.

The postexit period of this project saw a variety of outcomes. The consolidation threat was turned back when, after hearing the consulting team's preliminary recommendations, the judge decided not to move forward with the plan. The consultants' recommendation that the organizations providing court-based services adopt an integrated lead agency model was rejected by the agencies, although they did form a "consortium" and begin to work together in a more coordinated manner, for example, by developing a joint statement of "vision and mission" and a common manual of policies and procedures. While there was a general feeling that the consolidation plan that had provoked the review had turned out to be a good thing—because it had forced the organizations to start working together—some clients acknowledged that because the changes had not been structural, similar problems were likely to arise in the future.

Consulting Project 3. The comprehensive assessment projects—assessments of fit between client needs and available services—were developed in the context of Ontario's reform of its mental health system. (This reform effort was broadly directed at reducing the use of inpatient psychiatric facilities and promoting the use of community-based services.) As part of the reform process, the province appointed nine regional task forces to draw up specific reform implementation plans for their geographic areas. The task forces recognized that they needed data about clients and services before they could make such plans. Thus, the Health Systems Research and Consulting Unit was contracted by each of the task forces to conduct a comprehensive assessment project—a descriptive and inferential process using a standardized methodology to assess the client population's functional status and match it with different service levels.

These consulting projects differed from the other two projects in several ways: rather than being time-limited studies concentrating on a single facility or set of services, the assessment projects were broad-based

investigations, and the provincewide assessments continued for some four or five years. The preentry period for most assessment projects, then, was also the postexit period for one or more other assessment projects. In this way, the context for individual assessment projects was set by both the broader objectives of mental health reform and the experiences of other mental health reform task forces with their own assessments.

In each individual assessment project, the political task for the clients in the preentry period was promoting the need for the project to regional stakeholders. As one client explained, "selling" the assessment project entailed convincing people of the credibility of the consultants, the validity of their methods, and the utility of the information they could provide. The assessment projects were more likely to be accepted when they could be linked to ongoing efforts that were seen to be of value (e.g., the task forces' need for information) and were separated from endeavors that were viewed more cynically (e.g., ministry calls for accountability that seemed to result merely in more paperwork). For the consultants, preentry was a time for thinking about how the methodological and political learning from previous assessments might be applied to future projects.

During the entry period, as in the two projects already described, consultants and clients worked together to determine the scope of the project. Although the assessments were largely standardized in approach, they could be customized to meet local needs. Determining the extent and shape of customization was the main substantive focus of the entry period. The consultants used the entry period to build relationships and to learn about the local context. They arranged meetings with groups of local stakeholders—in particular, with the facilities and programs that would be the sites for much of the data collection—to inform them about the study and to seek their support.

During the diagnosis, the consultants worked with local project cocoordinators to gather data and refine their tools and methods. The political work of this period was to be available for questions and concerns that had not been foreseen, or addressed, in the preentry and entry stages.

In the intervention period, consultants analyzed the data and began to synthesize the detailed findings. Teams of consultants met with the local task forces or with steering committees composed of task force members to present the preliminary findings and to get advice about translating these findings into recommendations.

During the exit, the recommendations were finished, and the consultants prepared a final report. (The assessment project findings and recommendations varied somewhat by region, but generally the consultants found a high degree of "mismatch" between available services and the needs of the regional client populations. Thus most of the final reports noted the need for more resources to be devoted to developing particular service sectors.) Also during this stage, the consultants answered questions about the implications of the findings and fielded requests for different or more extensive analyses of the data.

In the postexit period, assessment project findings and recommendations were incorporated into the reports and recommendations issued by the regional task forces. As the clients explained, the results were useful for reinforcing the importance of problems that the task forces had already identified and for providing evidence to "make the case for change" in system policy and planning. For the broader research community, the nine completed assessment projects now stood as a provincewide database to be used to explore various questions about system clients and service delivery.

Discussion

The Use of Knowledge in Consulting Projects

Based on the three case studies we explored, consulting seems to be effective in promoting many of Weiss's models of knowledge use. Certainly, all three consulting projects contained elements of the problem-solving model. In each case, the decision to engage consultants was driven by an upcoming problematic change that the clients felt they lacked the capacity to address. In projects 1 and 2, the problem-solving function also looked very much like Weiss's political model of use, in which research evidence is used to support predetermined conclusions. That is, in these two projects, an important reason for hiring consultants was to gather evidence that would support the clients' own arguments: in project 1, the clients were looking for information that would reinforce their resistance to losing beds; in project 2, the steering committee wanted to forestall the consolidation of services at a single court. The effectiveness of these political uses of consulting-generated knowledge appear to be mixed. In project 1, the beds were lost despite the evidence compiled by the consultant. In project 2, the consolidation did not take place.

There is clear evidence that other types of use were also successfully accomplished. "Enlightenment" occurred in each project. For example, in project 3, one consultant explained that he knew that the consultants' work was being used when he began to perceive a "buzz" about the results and to be deluged with questions from the clients about the findings. Several clients in that project talked about the ways in which the data had "moved people forward" in making their recommendations. In project 2, the consultants' interviews with personnel from the different programs about the principles of court-based service provision provided a starting point for the new consortium to create a mission statement. In project 1, the experience of working with the consultant to make recommendations renewed a newly appointed administrator's commitment to implementing best practices in the facility.

In talking about the impact of the consulting projects during the postexit stage, clients identified many other uses. In project 1, an administrator described a relationship with the consultant in which she sought her advice on matters beyond those directly pertaining to the consultation. In project 3, the decision to use local coordinators to oversee the data collection had the effect of building local capacity for interpreting and applying research data. One of these co-coordinators, for example, explained how she was using the assessment data from her own facility for her quality assurance duties. In project 2, a member of the consulting team was later contracted by the consortium to write its new policies and procedures manual. These types of use seem to come under Weiss's description of the interactive model of use.

Conditions That Promote the Use of Knowledge

Three main categories of factors facilitate the use of knowledge in consulting projects: First is the urgency of the problem or issue that initiates the project. When clients identify a pressing need and are willing to pay consultants to help them respond, they are likely to be motivated to use the knowledge generated by the consultants. When the need is perceived to be less urgent or when the problem is not recognized by the clients themselves, the chances of the knowledge being used are reduced.

Second, use is promoted by specific characteristics of both consultants and clients. From the clients' point of view, knowledge is more likely to be used when the consultants are perceived to be accessible, organized, expert, and credible. Clients initially assess these qualities during the

preentry stage (indeed, they seem to constitute the main criteria in hiring decisions), but they must be continually enacted by consultants in various guises throughout the entire life of a project. From the consultants' point of view, clients need to be open (and open-minded), communicative, and committed to the consulting process. Most important, they must be willing to work with the consultants in order to agree on their expectations and the scope of the consultation, an agreement that is often negotiated and renegotiated over the life of the project.

Third, the use of knowledge seems to be facilitated by several strategies directed at promoting the clients' participation and collaboration. All three projects used steering committees to integrate the views of local experts into the design, conduct, and interpretation of the research. In project 1, the consultant sought out particular informants and conveyed her respect for their knowledge by the way in which she engaged them in discussion. In project 2, which the lead consultant explicitly construed as an exercise in conflict resolution, a stakeholder workshop was held so that all voices could be heard and a consensus reached. The implementation of these strategies of participation and collaboration constitutes the largest part of political work, which in turn may be broken down into ownership work (to promote clients' "buy-in" to recommendations), credibility work (to secure the consultant's role as an honest broker), resistance work (to smooth the conduct of the consulting project and the ensuing implementation of recommendations), and representation work (to ensure the acceptability of the product). The theory behind these strategies underlies the overall enterprise of interactive knowledge transfer: when knowledge users are involved in producing the knowledge, it will have greater "richness," relevance, and utility, and the knowledge-based recommendations will be more acceptable.

The three case studies also point out factors that may prevent the use of knowledge. As projects 1 and 3 demonstrate, many decisions about implementing knowledge-based recommendations (in these projects, decisions about bed allocation and resource deployment) take place outside the client/consultant system. The politics of these decisions are complex; it is unlikely that any single consulting process (or product) will dominate. As project 2 suggests, clients may sometimes have interests in the status quo that prevent them from fully accepting and implementing the consultants' recommendations. In this project, the clients were eager to exploit the consultants' finding that consolidation was not a good idea but were less enthusiastic about adopting the lead agency model.

Knowledge Transfer–Focused Consulting in Academia

As we noted, in many places knowledge transfer has become a requirement for academic researchers, particularly for projects funded by public granting agencies (e.g., Canadian Institutes of Health Research 2004). Researchers who wish to meet this requirement are looking for new ways of generating, synthesizing, and applying knowledge in order to make it relevant and useful to a variety of audiences. For example, researchers committed to making their work responsive to the concerns of marginalized communities are using community-based participatory research (Minkler and Wallerstein 2003). In this model, community members are active participants in defining the research question, collecting and analyzing data, and making recommendations based on research findings. Because its members are so involved in the research, the findings are likely to be both relevant and useful to the community.

Using consulting as a strategy for knowledge transfer may be an attractive option for health services and policy researchers employed by universities and other traditional academic institutions. In consulting, researchers engage decision makers, working with them to define and answer questions and to apply the results of these inquiries in policy and practice. As in community-based participatory research, this joint engagement ensures the relevance and utility of the knowledge that is generated. Consulting work, and the ongoing relationships with decision makers that may ensue, gives academic researchers an opportunity to better understand the contexts in which policy and practice decisions are made and implemented. Such knowledge may then enrich their conceptualization of research questions and approaches. Furthermore, in some consultations the knowledge produced is of general interest to the field, and the consultant is able to write articles about aspects of the work for scholarly journals. Of the projects reviewed for this study, for example, both projects 2 and 3 resulted in such publications (Durbin et al. 2001, 2004a, 2004b, 2004c; Macfarlane et al. 2004).

The framework of consulting is well suited to the task of engaging the health sector. Its structure—the idea of contracting for delivery of a service—is familiar to the high-status individuals who make up the community of decision makers. Hiring academics as consultants allows decision makers to access both the applied research skills of this group and their expertise and knowledge in areas such as the critical appraisal of

evidence and the synthesis of best practices. In many of the political contexts in which decision makers operate, developing a link to the prestige of academia may also prove advantageous. Ideally, for both academics and decision makers, consulting may become either a bridge to or part and parcel of a broader interactive knowledge transfer relationship.

Although the notion of offering paid expertise to organizations is one that is already well established in some academic fields (Czarniawska and Mazza 2003; Druckman 2000a, 2000b) and although consulting is a potential source of revenue for academic units, many characteristics of universities and other academic organizations make knowledge transfer and alternative models of research practice a difficult undertaking (Jacobson, Butterill, and Goering 2004). The structure of academia is such that members of the academy, individually and collectively, are largely accountable to their disciplines: ideas for new research therefore must be situated in the questions and methods of the discipline. Legitimacy is obtained through peer review of process and product. Rewards and incentives like tenure and promotion are dependent on meeting disciplinary standards. Thus, for consulting to be more widely embraced, academia must change some of its own structures and practices.

Conclusion

Consulting appears to be an effective strategy for carrying out an interactive model of knowledge transfer to enhance the use of research-based knowledge in decision-making environments. In this article we described a model of knowledge transfer–focused consulting, explored how knowledge generated in consulting is used, and identified three major classes of factors that appear to promote that use. Our model may be limited in that it is built from data collected from projects conducted by one consulting group, in one place, in one period of history, but we are confident that it suggests lessons that are more broadly generalizable.

The success of consulting in facilitating knowledge transfer between academic researchers and decision makers seems to rest on several characteristics of the process: the genesis of most consulting projects in change that presents an urgent challenge or threat to the client group; the "service" model of the process, in which clients pay consultants to provide specific knowledge, expertise, and/or skills within a defined scope; the mutual, and ongoing, contribution by consultants and clients

to defining that scope; the consultants' explicit attention to creating a process that respects their clients' local expertise and political reality; and the consultants' efforts to promote the utility of their knowledge-based recommendations through strategies of participation and representation.

Each of these characteristics suggests more general guidelines that may be applied to knowledge transfer endeavors. Knowledge transfer should begin with the needs of knowledge users, although researchers may help users define these needs. It is important that the scope of a knowledge transfer project or relationship be mutually determined, not dictated solely by the demands of either the researchers or the users of that knowledge. Finally, process and product are inextricably linked: a useful product can be the result only of a process that is deliberate, respectful, grounded in the users' context and the researchers' expertise, and open to constant renegotiation.

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